BURRAGE (W. L.)

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Retrodeviation of the Pregnant Uterus

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Case of Pregnancy in an Incarcerated Cornu and a Case Complicated by an Ovarian Tumor.

WITH REMARKS.

BY

W. L BURRAGE, M. D.,

BOSTON, MASS.,

SURGEON TO DISEASES OF WOMEN, ST. ELIZABETH'S HOSPITAL; GYNECOLOGIST TO OUT-PATIENTS, CARNEY HOSPITAL; CLINICAL INTRUCTOR IN GYNECOLOGY, HARVARD UNIVERSITY.

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CASES OF RETRODEVIATION OF THE PREGNANT UTERUS, INCLUDING A CASE OF PREGNANCY IN AN INCARCERATED CORNU AND A CASE COMPLICATED BY AN OVARIAN TUMOR; WITH REMARKS.[1]

BY W. L. BURRAGE, M.D.

I PRESENT brief histories of six cases of retroversion of the pregnant uterus and fuller histories of two other cases that have come under my observation during the last five years, eight in all. The diagnosis of pregnancy was well established in every case.

The first five cases were treated as out-patients, and their subsequent histories are necessarily incomplete.

There were five cases (I to V) of uteri about two months gone and in the second or third degree of retroversion; four were treated by replacement by means of bimanual manipulation, or by packing and a pessary. There was one case (V) of an incarcerated uterus three and a half months pregnant, that, having been replaced, carried the fetus to term. Two years later the woman appeared with the uterus in the third degree of retroversion and two months pregnant. Of the two cases reported in full, Case VII was pregnancy of three months' developing in the incarcerated right cornu of the retroflexed uterus. In this and in the following case it was necessary to give ether to make clear the diagnosis and to replace the uterus. Case VIII was a retroflexed and incarcerated uterus four and a half months pregnant, with prolapse of the cervix at the vulva, and an ovarian cyst the size of a cocoanut. It was treated by bimanual replacement of the uterus

[1] Read before the Obstetrical Society of Boston, Jan. 12, 1895.

and by ovariotomy, with the result of an uneventful convalescence and a living child at term.

CASE I. S. B., twenty-seven, married eighteen months, sterile. First seen June 1, 1891. Complained of vomiting every morning, and weakness for two months. Last catamenia March 20th. Diagnosis: retroversion, third degree; pregnancy, two months. The uterus was replaced by means of traction on the cervix with a tenaculum, and pressure on the fundus with a finger in the rectum. June 4th, a Thomas soft-rubber retroversion pessary was fitted. July 16th, the uterus was high up in the pelvis, and the pessary was removed.

CASE II. L. C., twenty-five, married eight months, sterile. First seen May 19, 1892. Last catamenia May 5th. Diagnosis: retroversion, uterus somewhat enlarged. She was packed for fourteen treatments, twice a week. Vomiting of pregnancy began June 1st, and continued. July 18th, there was no question as to diagnosis of pregnancy. August 11th, the vomiting had ceased, and the uterus was so high in the pelvis that no support was necessary.

CASE III. A. O., thirty-two, married twelve years; one child, two and a half years old; no abortions. First seen March 12, 1894. Catamenia irregular for the last two months; constant pain in the right inguinal region for the last week. Catamenia always regular until two months ago, and since then has flowed one day about every week. Diagnosis; retroversion, third degree; pregnancy, two months. The fundus uteri was replaced bimanually. March 19th, the uterus was again replaced, with the patient in the knee-chest position, and a Thomas soft-rubber retroversion pessary fitted. Patient not seen again.

CASE IV. A. E., twenty-one, single. First seen March 15, 1894. No catamenia for two months;

morning sickness and pain in the breasts. All the signs of pregnancy. Diagnosis: retroversion, third degree; pregnancy, two months. Not treated.

Case V. A. C., thirty-eight, married fourteen years; six children, the youngest four; two abortions. First seen May 23, 1890. Last catamenia, February 8th. Complained of difficult micturition and pain in the small of the back for two months. Diagnosis: retroversion and incarceration of uterus; three and a half months pregnant; lacerated cervix; cystocele and rectocele. The cervix was high up under the pubic arch, and the fundus jammed in the hollow of the sacrum. With the patient in the knee-chest position the uterus was replaced. April 28, 1891, she reported that she had carried the child to term, and that it had been removed dead (by version probably). The uterus was in good position.

March 17, 1893, she again came under observation. The uterus was then in the third degree of retroversion and two months pregnant. It was treated by replacement and packing for six treatments, and then it remained in place without artificial support.

Case VI. K. McC., twenty-eight, married seven weeks, sterile. First seen Dec. 6, 1894. Backache for a year, associated with dyspepsia and constipation. Leucorrhea. Catamenia regular, of four to five days' duration, using six to eight napkins but accompanied by increased backache. Last catamenia October 26, 1894. In November flowed slightly one day. Backache very bad since marriage, also almost constant nausea and indigestion. Pains in stomach and breasts. Unable to work. Diagnosis: retroversion, axis of vagina; pelvic inflammation; cervix long and soft; uterus large, immovable and tender; breasts, suspicions of pregnancy.

She was treated by light packing with ichthyol and

glycerine cotton for five treatments. Pain somewhat relieved by bromide. December 31st, the uterus being free from adhesions and having increased in size to that of two months' pregnancy, it was replaced by traction on the cervix with a tenaculum and lifting the fundus out of the hollow of the sacrum with a finger in the rectum. A little bimanual manipulation then restored it to a normal position. Cervix very soft. Discoloration of vagina. No question as to diagnosis. The uterus being so large, it was thought that there was little danger of its becoming reincarcerated and no pessary or packing was used.

January 3d, she returned and the uterus was again wedged in the pelvis in retroversion. It was again replaced, the patient being in the knee-chest position, and an Albert Smith retroflexion pessary placed. She is now wearing the pessary with comfort, and the uterus is in good position. She has been partially relieved of her nausea.

Case VII. M. X., twenty-six, wife of a physician, married three months. First seen November 23, 1893. Last catamenia September 8th. Catamenia usually regular and painless. Suffered with severe pain in left ovarian region on September 29th, after getting her feet wet. Nausea and vomiting began the latter part of October, and had persisted with great severity up to the time when I saw her. Early in November, after she had been vomiting persistently for ten days and was losing flesh and strength very rapidly, her husband introduced a bougie four inches into the uterus, and left it there over night. Next day he put in another. As a result, there was some flowing (one napkin) for a day, and relief from the symptoms for a week. A week before my visit the vomiting began again with renewed force. She could keep nothing on her stomach, vomited froth and bile every few

moments, had lost fifteen pounds in weight and was becoming very weak.

Dr. X. made use of a large number of drugs without much avail. Morphine and bromide controlled the vomiting for a short time, but were poorly tolerated. November 21st, he dilated the cervix with a Palmer dilator to a one-inch spread of the blades. Since then there had been slight flowing, but no relief of the symptoms. The urine was negative. Temperature 100°.

When I saw Mrs. X., two days later in consultation, I found a tall, well-developed, dark-complexioned woman of a neurotic type. The abdominal walls were reasonably lax, so that the bimanual examination was as satisfactory as is usual in nulliparæ who are not too fat. There was some mucus and blood in the vagina. The uterus, which was enlarged to the size of three months' pregnancy, was retroflexed in the second degree and immovable. In the cul-de-sac to the right there was a mass the size of a hen's egg, that I took to be a cystic right ovary, or an extra-uterine pregnancy. The cervix appeared to be very long and the os was patulous.

It seemed best to me to give an anesthetic, in order to make a more thorough examination. Ether was given accordingly. With the aid of the anesthetic I was able to determine that the mass in the cul-de-sac to the right was not the right ovary, nor the products of extra-uterine fetation, but the enlarged right horn of the uterus that had somehow become incarcerated in the bottom of the pelvis. After considerable vigorous bimanual manipulation, I succeeded in rocking the large horn by the promontory of the sacrum, and put the uterus into its proper position Then it was possible to map out the asymmetrical uterus and also both ovaries normally placed and of normal size. Diagno-

sis: pregnancy at three months in cornu; retroflexion and incarceration. A half-grain suppository of morphine was put in the rectum, and the patient put to bed.

The relief from symptoms was marked. With the exception of a slight relapse to vomiting on November 30th and December 1st, pregnancy was from this time uncomplicated; and Mrs. X. was delivered of a living girl baby, weighing five and three-quarters pounds, on April 28, 1894. I saw Mrs. X. again August 31, 1894. The uterus was then symmetrical, in good position, and of normal size. Left ovary small. No evidence of rudimentary uterine horn.

Case VIII. D. H., twenty-six, married two years; one child, thirteen months; no abortions. First seen October 25, 1893. Had an attack of flowing in August, 1892, two weeks after her baby was born and had not flowed since until she had a normal menstruation of five days, May 10, 1893. Was in labor five days; ether and forceps used; baby weighed ten pounds and a quarter; in bed three weeks after labor; nursed child. She noticed prolapse of the parts at the vulva as soon as she got up, and the condition persisted in spite of treatment by her doctor with packing and a ring pessary.

Early in September she thought she might be pregnant, being unable to eat her usual articles of diet, and having cravings as at her previous pregnancy. Accordingly she weaned her child. She noticed at this time that the womb came outside the body; and she suffered with dysuria and was unable to sit or walk with comfort. She also suffered from constipation and from pain above the pubes, that had been increasing in severity ever since. She complained chiefly of this pain when I saw her at the Carney Hospital, October 25, 1893. I found the cervix uteri enor-

mously elongated, with as much as an inch and a half projecting from the vulva; deep laceration of the perineum; pelvis filled with a semi-solid tumor, apparently the retroflexed uterus about four and a half months pregnant. Above and on the right, lying on the pelvic brim, was a tumor of indefinite outline and the size of a cocoanut.

By forcible bimanual manipulation I was able to partially dislodge the pelvic tumor, and the patient was kept in bed until six days later, October 31st, when she was given ether and a thorough examination made. Dr. F. W. Johnson kindly saw the case with me in consultation. We found the fundus uteri out of the pelvis, and the cervix high; and we also made out a cystic tumor apparently of the right ovary, the size of a cocoanut.

On account of the limited space in the abdomen, and the rapidly growing uterus, it seemed best to remove the cyst by abdominal section. Having allowed a sufficient time to elapse after the etherization to prevent all fear of miscarriage, I performed ovariotomy November 10, 1893. The patient made a normal convalescence, and was delivered of a living child March 23, 1894. I saw her and her child at my office May 9th, and the uterus was then in good axis but low in the pelvis, which was justo-minor to a slight degree. I shall report the case in more detail at some future time.

In looking over the literature of the subject of retrodeviations of the pregnant uterus, I got the impression that the condition is of fairly common occurrence, and also that its early detection and treatment are of much more importance than one would be led to expect from the cursory manner in which the subject is treated by the text-books.

The most recent and most complete work on this

subject that I have found is an article by Dr. Sigmund Gottschalk, of Berlin,[2] "Zur Lehre von der Retroversio uteri gravidi." Gottschalk contrasts a statement made in the last edition of Schroeder's text-book, to the effect that retroversion of the pregnant uterus is seldom found, and that most cases right themselves during pregnancy, with a statement of Chrobak's that in his (Chrobak's) experience the retroverted pregnant uterus only seldom rights itself, whereas the retroflexed gravid uterus, in a vast majority of cases, does not right itself at all.

Gottschalk makes a strong plea for the distinction of retroversion from retroflexion, and sides with Chrobak in his views as to the spontaneous righting. He thinks that it is only those uteri that were retroverted before becoming pregnant that we can expect to right themselves, and with them there is much doubt. Those becoming retroverted or flexed during pregnancy have a much more unfavorable prognosis.

To show the gravity of the condition he collected sixty-seven cases of death due to retrodeviation of the pregnant uterus; the causes of death including uremia and exhaustion, gangrene of the bladder, tearing of the bladder, peritonitis in consequence of gangrene of the bowel, and occlusion of the bowel from torsion of the uterus on its axis.

I have found a case of hemichorea in pregnancy caused by acute retroflexion of the gravid uterus, the chorea disappearing on the replacement of the uterus.[3] Also, a case of pregnancy in a retroverted uterus, with distension of the bladder and sloughing of the vesical mucous membrane, in which the patient miscarried at five months; recovery.[4]

[2] Archiv für Gynækologie, 1894, xlvi, 358-383.
[3] Cameron, J. C.: Montreal Medical Journal, 1891-2, xx, 499-501
[4] Corkhill, J. G. G.: Lancet, 1887, ii, 1311.

W. S. Stewart reported before the International Medical Congress at Washington, in 1887,[5] the history of a case of retroflexed pregnant uterus, first seen when two and a half months along, which was allowed to go to term. The uterus was replaced during labor; after the os was dilated it fell back, but was again replaced, and the woman was finally delivered of a living child, and made a good recovery.

This case is to be contrasted with one reported by Wenning,[6] of dextrotorsion of the pregnant uterus simulating extra-uterine pregnancy, in which he did celiotomy at the sixth month, and the patient aborted and died of sepsis; and also with a case reported by Gottschalk,[7] where there was acute obstruction of the bowels due to a retroflexed pregnant uterus at four months. He performed celiotomy when the patient was practically moribund, and she died in twelve hours.

It is plain to my mind that retrodeviation is a complication of pregnancy that is very likely to endanger the mother's health, or even her life; and the earlier in pregnancy it is diagnosticated and treated, the better the prognosis.

As to treatment, one must distinguish clinically between the retrodeviations (1) *non-incarcerated*, and the uterus that has grown so large that the fundus cannot rise by the promontory of the sacrum, or the (2) *incarcerated.*

As to the first class, it is admitted that a retroverted and pregnant uterus, although firmly adherent, may rise up into the pelvis without artificial aid, such is the softening effect of pregnancy on adhesions. That is to say, it is possible it may not enter Class 2. It is seldom that the attending physician is able to diagnosticate a retrodeviation occurring during pregnancy from

[5] See Transactions, ii, 446.
[6] American Journal of Obstetrics, 1890, xxiii, 155–167.
[7] Loc. cit., p. 361.

one originating before pregnancy. When seen in the early months, especially when adhesions are present, the presumption is that the malposition antedates the pregnancy. Such a distinction is, to my mind, of no importance as far as treatment is concerned.

I contend that it is safer and that the danger of abortion is less, to treat all retroverted pregnant uteri as soon as diagnosticated, with packing and pessaries until such time as the organ has become so large that it cannot fall backward into the pelvis. This will be between the third and fourth month.

I think that there is a belief in the profession that pregnant uteri should not be treated by vaginal packing, and that packing the vagina causes abortion. This I believe to be erroneous. Certainly such treatment did not cause abortion in the cases I have reported. When the uterus is replaceable and has been replaced, it should be held in the normal position by a suitably-fitted pessary. It is well to leave out packing during the times that would be the menstrual periods.

As regards Class 2, the incarcerated uteri, the treatment is to dislodge the fundus and put it in its proper position as soon as possible. To this end ether may be necessary, although in a majority of cases the replacement is readily performed by placing the patient on her back with knees drawn up, seizing the cervix with a tenaculum and pulling downward on this, and at the same time pushing the fundus up with one or two fingers in the rectum.

When the fundus is emerging from the pelvis, I let go with the tenaculum and pushing the cervix backward with a finger in the vagina, massage the fundus forward, with my other hand on the abdomen. When this method proves unsuccessful, I put the patient in the knee-chest position and repeat the procedure.

In Case VIII, which exhibited a most unusual com-

bination of pathological conditions, the uterus was so large, being four and a half months pregnant, that very forcible manipulation succeeded in only partially dislodging the fundus. Several days later, however, it was found in its proper position.

The small size of the child in this case is of interest. It seems probable that the surgical interference and the cutting off of the ovarian artery on one side was accountable in a measure for this. It is safe to say that had the case been allowed to take its course without surgical aid, she would either have aborted or had a difficult labor.

In Case VII, it occurs to one as strange that the introduction of two bougies four inches in the uterine cavity and subsequent dilatation of the cervix did not produce abortion. The explanation is found in the fact that the products of conception were located in the uterine horn and were not reached by the bougies.

Cases VII and VIII are striking instances of the great tolerance of the pregnant uterus; and their happy outcome, as well as the results of my investigation of the literature of the subject, confirm me in my belief that all retrodeviations of the pregnant uterus should be treated by replacement as soon as diagnosticated.

Symptoms of exaggerated backache, dysuria, intractable nausea and vomiting, or pelvic pains occurring during early pregnancy, should lead at once to a bimanual examination, and the physician should satisfy himself that the uterus is in proper position.

317 Marlborough Street.